

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-033708

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 37 Primary Registration District No. 5119 Registrar's No. 31

STATE FILE NUMBER

FILED OCT 2 1962

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Centralia Township</u>		c. CITY OR TOWN <u>Centralia</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>near Centralia, Mo.</u>		d. STREET ADDRESS (If outside, give location) <u>Rte 2</u>	

3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>E</u> Last <u>Olds</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>27</u> Year <u>1962</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/8/1883</u>	9. AGE (last birthday) <u>79</u> Years <u>8</u> Months <u>19</u> Days	10. IF UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Dentistry</u>		
11. BIRTHPLACE (City and state or country) <u>Boone County, Mo.</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>George Thomas Olds</u>			13b. MOTHER'S MAIDEN NAME <u>Frances Blythe</u>		
14. NAME OF HUSBAND OR WIFE <u>Nora Olds</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. INFORMANT <u>Mrs. Nora Olds, Centralia, Mo.</u>			17. ADDRESS		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arterial hypertension - 7 months ago</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year ____ - ____ - ____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	20f. CITY, TOWN, OR LOCATION _____	COUNTY _____	STATE _____
21. I attended the deceased from <u>Nov 2, 1960</u> to <u>Mar 20, 1962</u> and last saw him alive on <u>March 20, 1962</u> Death occurred at <u>10</u> A.m. on the date stated above, and to the best of my knowledge, from the causes stated.						

22a. SIGNATURE (Degree or title) <u>L. Lochner, M.D.</u>		22b. ADDRESS <u>110 West 5th Centralia Mo</u>		22c. DATE SIGNED <u>9/29/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Sept. 29, '62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>

24. FUNERAL DIRECTOR <u>Bice & Meador Centralia, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 28 - 1962</u>	26. REGISTRAR'S SIGNATURE <u>Maud M. Bride</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

VS 300
Rev. 4/59

6100

26100

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94200

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1290-0

132-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

B. J. Madon

Licensed Embalmer No. 4876

P. O. Address Centralia, Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.